14-17 Year Old AHCCCS EPSDT Tracking Form

Date: | Last Name: | First Name: | AHCCCS ID#: | Age:

Primary Care Provider Name and Office Phone Number: | Contractor: | DOB:

Accompanied by: | Allergies:

Weight: | Percentile: | Height: | Percentile: | BMI: | Percentile:

HISTORY:

Parental Comments/Concerns:

Vision Chart Exam	
OD	
OS	
OU	
Corrected	uncorrected

Temp:	
Pulse:	
Resp:	
BP	
BP elevated?	

Dental Screen: Date of last exam: _____ Next appt: _____ Routine _____ Urgent _____ Parent advised _____

Nutritional Screen: Adequate _____ Inadequate _____ Supplements: _____

Hearing Screen: Within normal limits? Yes ____ No ____ **Speech:** Within normal limits? Yes ____ No ____

Developmental Screen: Age Appropriate? (e.g., school attendance, reading at grade level) Yes ____ No ____

If suspicious, specific objective testing performed _____

Behavioral Screen: Age appropriate? (HEADDSS, GAPS, parental interview) Yes _____ No _____

PHYSICAL EXAM

Are the following normal?	Yes	No	Describe abnormal findings:	LABS ORDERED:
1. Skin/Hair/Nails				Tuberculin Test _____
2. Ear/Hearing				**(perform if at risk)**
3. Eyes/Vision				Urinalysis _____
4. Mouth/Throat/Teeth				**(Perform at age 14)**
5. Nose/Head/Neck				Hgb/Hct _____
6. Heart				**(Perform at age 14)**
7. Lungs				**Additional Labs ordered:**
8. Abdomen				Lipid profile _____
9. Genitourinary/Breast **Tanner Stage**				Other tests: _____
10. Extremities				**Confidential Documentation:**
11. Spine (scoliosis)				**See attached note please:** _____
12. Neurological				

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** ____ **No** ____ **Delayed?** ____ **Deferred?** ____

Given today? **Hep B** ____ **Td** ____ **MMR** ____ **Influenza** ____ **Varicella** ____ **Hep A** ____ **Other** _____

ANTICIPATORY GUIDANCE

- Drowning/sun safety
- Seat belts/driving safety
- Sports/injury prevention
- Nutrition/exercise
- Dental and self care
- Sex education/counseling
- Self control
- Peer refusal skills
- Social interaction
- Depression/anxiety
- Tobacco/alcohol/drugs/inhalants
- Violence prevention/gun safety
- Education goals/activities
- "Safe at Home?"
- Parenting advice
- Family involvement
- Next appointment

REFERRALS:

Behavioral ____ **Dental** ____ **Nutritional** ____ **WIC** ____ **Developmental** ____ **Specialty** ____ **Other** ____

Yes _____ No _____

Clinician Name (print): Clinician Signature: See Additional/Supervisory Note?

Revised January 1, 2004